

January 5, 2018

The Honorable Eric D. Hargan, Acting Secretary
U.S. Department of Health and Human Services
200 Independence Avenue, SW
Washington, DC 20201

Dear Acting Secretary Hargan:

The undersigned organizations appreciate the opportunity to comment on the North Carolina Medicaid and NC Health Choice Amended Section 1115 demonstration waiver application.

We support aspects of the proposal that are likely to expand and improve care for Medicaid beneficiaries, including the regional public-private pilots. However, we are deeply concerned about proposals to impose work requirements and premiums, and to waive the IMD exclusion. We urge you to reject these aspects of the proposal that fail to meet the statutory requirements for an 1115 demonstration.

I. North Carolina's Proposed Public-Private Regional Pilots Could Foster Innovative Improvements in Care Delivery

We support North Carolina's proposal to establish public-private regional pilots in two to four areas of the state to improve beneficiaries' health and lower costs. The pilots would employ evidence-based interventions to address social determinants of health such as housing, transportation, food, and interpersonal safety and toxic stress. The proposal would establish pilots based on a competitive procurement process, and the pilots would be responsible for defining their target populations, objectives, and interventions.

As the state and HHS work to develop terms and conditions, we offer a few recommendations:

- 1. Invest in sustainable interventions.** While providing additional services may help the target populations in the short-term, pilots that invest in changes to their systems and infrastructure will offer the opportunity for long-term delivery system reforms that could have lasting effects. For example, providing enhanced care coordination services to individuals with physical and behavioral health care needs may help them access needed care, improve health outcomes, and reduce unnecessary utilization of emergency services. However, investing in systems to share data and integrate care between physical and behavioral health care providers may allow for long-term, sustainable improvements in care delivery and coordination.
- 2. Define specific objectives and benchmarks.** North Carolina's proposal includes a broad range of target populations and objectives. This is appropriate, if each pilot is intended to have the flexibility to define these areas based on the needs of its population. However, in order to appropriately evaluate the success of each pilot, the population, intervention, and objectives should be clearly defined, with regular benchmarks to evaluate progress. Specific health care access, quality, and health outcomes metrics should be included to ensure the intervention is supporting beneficiaries' overall health.

3. **Ensure that pilots supplement and integrate with existing health programs.** North Carolina is fortunate to have substantial and innovative community-led health systems. The proposed regional pilots should define how they intend to use additional waiver funding to supplement, rather than supplant or increase the complexity of, the existing health infrastructure.

II. A Work Requirement Would Harm People Who Cannot Work, Those Looking For Work, and Those Who Are Working

North Carolina's proposal would condition Medicaid eligibility for many adults on work or work-like activities. The proposal includes narrow exceptions for adults who are caring for a dependent minor child, an adult disabled child, or a disabled parent. The proposal would also exempt those who are receiving active treatment for a substance use disorder, and those who are medically frail. The proposal does not appear to exempt people with chronic health conditions other than substance use disorders, or those who are caring for family members other than dependent children or a disabled parent or child.

North Carolina states its waiver request is intended to improve health, maximize value, and increase access to care. A work requirement would be counterproductive to achieving these laudable goals: research has shown that work requirements do not lead to increased long-term employment or reduced poverty.¹

A. Work requirements are contrary to the goal of Medicaid.

Section 1115 of the Social Security Act allows the Secretary of HHS to waive certain Medicaid statutory requirements when deviating from these requirements is necessary to implement state demonstration projects that promote the objectives of the Medicaid program.² North Carolina's proposed work requirement doesn't meet the standards for an 1115 demonstration project.

Work requirements are contrary to the core mission of Medicaid to provide health coverage to low-income people so they can get the health care services they need. Research shows that most people with Medicaid coverage who can work do so, and for people who face major obstacles to employment, harsh requirements such as limiting their eligibility for health coverage will not help overcome them. Nearly 8 in 10 non-disabled adults with Medicaid coverage live in working families, and nearly 60 percent are working themselves. Of those not working, 35 percent reported that illness or a disability was the primary reason, 28 percent reported that they were taking care of home

¹ Hannah Katch, "Medicaid Work Requirement Would Limit Health Care Access Without Significantly Boosting Employment," July 13, 2016, Center on Budget and Policy Priorities, <https://www.cbpp.org/research/health/medicaid-work-requirement-would-limit-health-care-access-without-significantly>.

² Judith Solomon and Jessica Schubel, "Medicaid Waivers Should Further Program Objectives, Not Impose Barriers to Coverage and Care," Center on Budget and Policy Priorities, August 29, 2017, <https://www.cbpp.org/research/health/medicaid-waivers-should-further-program-objectives-not-impose-barriers-to-coverage>.

or family, and 18 percent were in school.³

The proposal does nothing to increase the availability of appropriate jobs across the state, or to provide Medicaid beneficiaries with transportation, childcare, education, job search services, or training that could help them find and hold a job. Medicaid beneficiaries living in rural areas without job opportunities or transportation would likely struggle to meet the requirements.

The proposal would also harm those who *are* working. Tracking hours worked would likely lead to errors and coverage terminations for those who are working or participating in a job training program, and could cause working individuals to erroneously lose coverage and face additional burdens in proving their eligibility. Workers whose hours vary, such as many hourly and seasonal workers, would be particularly likely to lose health coverage, even if they are meeting the policy's requirements.

North Carolina's amendment could end up keeping people from gaining employment, because without health services, it could be more difficult for them to find and hold a job. Ohio's Department of Medicaid found that three-quarters of Medicaid expansion enrollees who were looking for work reported that Medicaid made it easier to do so, and more than half of those who were working said that Medicaid made it easier to keep their jobs.⁴

B. North Carolina's Proposal Does Not Include a Hypothesis or an Evaluation Design

North Carolina's proposal does not include a hypothesis with regard to the proposed work requirement that the state intends to test, nor does it include an evaluation design of any kind. 1115 demonstrations must test a reasonable hypothesis to promote the objectives of the Medicaid program. This proposal does not include a reasonable hypothesis or an evaluation of its success.

C. North Carolina's Proposal Doesn't Adequately Address Implementation of a Work Requirement

Even if a work requirement was allowable in Medicaid, North Carolina's proposal should be rejected because the state has not provided assurances that the requirement it proposes will be administered fairly and effectively. Effective implementation would be burdensome and costly, requiring new procedures, system changes, and considerable time from eligibility workers. The state must also establish systems for verifying exemptions, screening, tracking, and sanctions.

The administrative challenges associated with implementing work requirements and time limits would be more pronounced in Medicaid than SNAP and TANF, which have struggled with implementation. SNAP and TANF require substantial interactions with participants, including interviews and frequent reporting. Even with this more intensive case management model, states have encountered obstacles to accurately applying these policies. Medicaid currently has a

³ Rachel Garfield, Robin Rudowitz, and Anthony Damico, "Understanding the Intersection of Medicaid and Work," Kaiser Family Foundation, February 2017, <http://kff.org/medicaid/issue-brief/understanding-the-intersection-of-medicaid-and-work/>.

⁴ Ohio Department of Medicaid, "Ohio Medicaid Group VIII Assessment: A Report to the Ohio General Assembly," <http://medicaid.ohio.gov/Portals/0/Resources/Reports/Annual/Group-VIII-Assessment.pdf>.

streamlined eligibility determination process which relies heavily on online applications and electronic data verification. State experience implementing work requirements in TANF also suggests that adding similar requirements to Medicaid could cost states thousands of dollars per beneficiary.⁵

States' administration of the SNAP time limit was error prone, applied inaccurately, and led to eligible individuals being denied benefits.⁶ When first implemented, FNS did a study and found that policies were "difficult to administer and too burdensome for the States." One of the biggest shifts was tracking benefit receipt over time, rather than circumstances in a single month, which was a fundamental change to program administration.⁷ North Carolina would likely face similar, if not even more significant challenges implementing a work requirement in Medicaid, which would jeopardize needed care for beneficiaries.

III. Premiums Create a Barrier to Care

Under Carolina Cares, individuals with income greater than 50 percent of the poverty line would be required to pay a monthly premium of two percent of income unless they can demonstrate a medical or financial hardship, are a member of a federally recognized tribe, or are a veteran. A person who fails to pay their premium within 60 days will be disenrolled from coverage and will not be allowed to re-enroll until they pay their missed premiums.

While states like Indiana, Iowa, and Montana have been allowed to charge premiums to people with income below the poverty line, no state has been allowed to disenroll people with incomes below the poverty line from coverage if they miss payments. And for good reason -- a robust body of research shows that imposing premiums on low-income individuals creates a barrier to care and fails to improve health outcomes.

A report from the Kaiser Family Foundation looked at research from 65 papers published between 2000 and March 2017 on the effects of premiums and cost sharing on low-income people enrolled in Medicaid and CHIP. The authors concluded that premiums are a barrier to obtaining Medicaid and CHIP coverage, with the largest effect among those with incomes below poverty. The research shows that while some individuals losing Medicaid or CHIP coverage move to other coverage, others become uninsured. Those with lower incomes are most likely to become uninsured. Once uninsured, people face increased barriers to accessing care, greater unmet health needs, and increased financial burdens.⁸

⁵ Gayle Hamilton et al., "National Evaluation of Welfare-to-Work Strategies: How Effective Are Different Welfare-to-Work Approaches? Five-Year Adult and Child Impacts for Eleven Programs," Manpower Demonstration Research Corporation, December 2001, Table 13.1.

⁶ USDA Office of Inspector General, "FNS Controls over SNAP Benefits for Able-Bodied Adults Without Dependents", September 2016, <https://www.usda.gov/oig/webdocs/27601-0002-31.pdf>.

⁷ Mathematica Policy Research, Inc., "Imposing a Time Limit on Food Stamp Receipt: Implementation of the Provisions and Effects on Food Stamp Participation" (2001)

⁸ Samantha Artiga, Petry Ubri and Julia Zur, "The Effects of Premiums and Cost Sharing on Low-Income Populations: Updated Review of Research Findings," Kaiser Family Foundation, June 2017, <http://www.kff.org/medicaid/issue->

There is also evidence from states with Medicaid expansion waivers that their premium protocols confuse beneficiaries. For example, in Indiana, where adults are required to pay between \$1 and \$100 in monthly premiums to enroll in a more comprehensive plan, three-quarters of people below the poverty line who did not make their payment said they missed the payment because it was unaffordable, they were confused about the process for paying, or they did not even know a premium was required.⁹ And in Iowa, where people below the poverty line can have their premium waived if they declare a hardship (as North Carolina proposes), only about five percent of enrollees with incomes between 50 and 100 percent of the poverty line do so.¹⁰ The difference between these states and North Carolina is that neither disenrolls people from coverage for missing their payments.

Finally, North Carolina does not offer a demonstration hypothesis for charging premiums to Medicaid expansion beneficiaries. With ample evidence of the effect premiums have on people's ability to access coverage and care, we do not believe there is a sound rationale for allowing North Carolina to further test a hypothesis centered around premiums.

IV. Proposal to Waive the IMD Exclusion for Psychiatric Care is Impermissible

North Carolina's proposal requests waiver of the IMD exclusion to provide "short-term behavioral health services that aim to stabilize beneficiaries experiencing a psychiatric crisis with the expectation of shifting them to less intensive, community-based setting[s]." Wholesale or broad waiver of the IMD exclusion through 1115 authority is not permissible. Several states have been granted permission through 1115 waiver authority to provide limited, well-defined IMD services for inpatient substance use disorder (SUD) treatment in conjunction with an evidence-based SUD services continuum of care or well-defined SUD related outcome measures. However, North Carolina's IMD request for inpatient psychiatric services is not specific to SUD treatment services. Section 1115 authority permits the Secretary to waive a number of provisions, but the statutory IMD exclusion (found in Section 1905) is not one of them.¹¹ It is widely accepted that legislation would be needed to alter the IMD exclusion or mental health services.¹²

V. North Carolina's Substance Use Disorder Services Proposal Falls Short

[brief/the-effects-of-premiums-and-cost-sharing-on-low-income-populations-updated-review-of-research-findings/](#).

⁹ The Lewin Group, "Healthy Indiana Plan 2.0: POWER Account Contribution Assessment, Prepared for Indiana Family and Social Services Administration (FSSA)," March 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/in/Healthy-Indiana-Plan-2/in-healthy-indiana-plan-support-20-POWER-acct-cont-assesmnt-03312017.pdf>.

¹⁰ Iowa Department of Human Services, "Iowa Wellness Plan Quarterly Report," October 2017, <https://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Waivers/1115/downloads/ia/Wellness-Plan/ia-wellness-plan-qtrly-rpt-jul-sep-2017.pdf>.

¹¹ Section 1115 permits the Secretary to "waive compliance with any of the requirements of Section 2, 402, 454, 1002, 1402, 1602, or 1902," not 1905.

¹² For example, the President's Commission on Combating Drug Addiction and the Opioid Crisis, Draft Interim Report (2017), page 3, stating in regards to the IMD exclusion: "The Commission recognizes that legislation would be necessary to repeal the exclusion in its entirety." <https://www.whitehouse.gov/sites/whitehouse.gov/files/ondcp/commission-interim-report.pdf>

In November of 2017, CMS revised its policy on how states can use 1115 waivers to improve their SUD treatment services for Medicaid beneficiaries.¹³ The revised policy maintains the goal of the original guidance “to provide a full continuum of care for people struggling with addiction,” and holds states accountable to six goals and six milestones in pursuit of that overarching goal. North Carolina’s proposal falls far short of CMS’ new guidance.

Aside from additional care coordination, North Carolina’s proposal solely seeks permission to reimburse for inpatient and residential care, which would not adequately address the opioid crisis or improve SUD services. Residential and Inpatient services can be critical both for people beginning recovery and for people in other stages of recovery, particularly people who have experienced recent relapse. However, North Carolina does not propose to reimburse additional outpatient and community-based SUD services, which are necessary for North Carolina to achieve the goals and milestones CMS enumerated in its November 2017 guidance. Many people need ongoing recovery supports — such as case management or peer supports — and outpatient care to maintain recovery upon leaving inpatient or residential care. Lack of access to outpatient services makes people more likely to relapse and more likely to return to inpatient or residential facilities, which is not only a bad outcome but is also expensive. While North Carolina’s State Medicaid Plan does include some intensive outpatient SUD services, the state should include a full continuum of community-based SUD care that meets the needs of and is accessible to beneficiaries in all phases of recovery.

Thank you for your willingness to consider our comments. If you need additional information, please contact Judy Solomon (Solomon@cbpp.org) or Joan Alker (jca25@georgetown.edu).

Center on Budget and Policy Priorities
Children’s Defense Fund
Epilepsy Foundation
First Focus
Georgetown University Center for Children and Families
HIV Medicine Association
Justice in Aging
National Center for Law and Economic Justice
National Health Care for the Homeless Council
National Multiple Sclerosis Society
United Way Worldwide

¹³ November 1, 2017 letter from CMS to state Medicaid Directors, available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>